Kentucky Employees' Health Plan
2011 Certification of Dependent Eligibility
Must be submitted for each dependent child ages 19 through 25

Section I: Statement of Dependency

Name of KEHP Member	Name of Dependent
KEHP Member's Social Security Number	Dependent's Social Security Number
KEHP Member's Phone Number	Dependent's Date of Birth

Section II: Dependent's Employment Status

1. Is this dependent employed? ☐ Yes ☐ No
2. If this dependent is employed, is he/she employed full-time or part-time? ☐ Full-time ☐ Part-time
3. If this dependent is employed full-time, does his/her employer offer group health insurance for which this dependent is eligible? ☐ Yes ☐ No

   Name and address of employer: _____

Section III: Acknowledgement

I, the member, and I, the dependent referenced above, do certify under penalty of law that the information I have provided on this affidavit is correct and complete. I understand that omissions or incorrect statements made by me on this affidavit could lead to (1) retroactive loss of benefits for the dependent named above; (2) disciplinary action, up to and including termination of employment; and (3) civil and/or criminal penalties.

I understand that this form is not an application for insurance coverage and that the purpose of this form is to establish eligibility of dependent persons named herein for the coverage provided under the Kentucky Employees' Health Plan.

I understand that this signed affidavit will be retained in my employee benefits file.

Print Name of KEHP Member	**Print Name of Dependent**
Signature of KEHP Member	**Signature of Dependent**
Date	**Date**

Mail to KEHP: 501 High Street, 2nd Floor, Frankfort KY 40601